Laurentian University

Advanced Practicum Final Report
Presented at Laurentian University
As a partial requirement
Of the Master of Social Work Program

By

Mark Hurley, RSW

The Experience of Strengths Based Practice and Reflexive Practice with Supervision At The Family Enrichment Centre of Sudbury, Ontario

Sunday, November 27, 2016

Thesis/Advanced Practicum Review Committee
Comité de soutenance de thèse / Stage spécialisé
Laurentian Université/Université Laurentienne
School of Graduate Studies/École des études supérieures

Title of Advanced Practicum Titre de la these / stage spécialisé	The Experience of Strengths Based Practice and Reflexive Practice At The Family Enrichment Centre of Sudbury, Ontario
Name of Candidate Nom du candidat	Mark Anthony Hurley
Degree Diplôme	Master of Social Work
Department/Program Département/Programme	Social Work
Date of Approval Date de la soutenance	December 12, 2016

APPROVED/APPROUVÉ

Examiners/Examinateurs:

(First Reader/Supervisor/Directeur(trice) de these / stage spécialisé) Dr. Diana Coholic

(Second Reader/Co-supervisor/Co-directeur(trice) de these / stage spécialisé) Dr. Leigh MacEwan

(Committee member/Membre du comité / stage spécialisé)

Approved for the School of Graduate Studies
Approuvé pour l'École des études supérieures
Dr. David Lesbarrères
M. David Lesbarrères
Director, School of Graduate Studies

Abstract

My Master of Social Work practicum took place in a non-profit social service agency with the City of Greater Sudbury called The Family Enrichment Centre. This agency specialized in providing therapeutic mental health services to a cross section of people within the Greater City of Sudbury and surrounding communities.

I had two primary goals. The first was to learn different treatment modalities in my clinical work with individuals that fit within the Strengths Perspective. The second was to utilize clinical supervision in its various forms to further develop a reflexive clinical orientation.

I was able to build upon my existing experience with treatment modalities I had previously used and to practice some new treatment modalities by using the clinical structures and resources built into the agency. These clinical structures and resources included common intake, assessment and recording tools as well as training opportunities and information on a variety of clinical modalities.

I was also able to develop a more reflexive practice through the use of one to one clinical supervision with a clinical psychologist, ad hoc individual supervision/consultation with other therapists and regular group consultation with other therapists. Participation within their anger management group and bi-weekly individual spiritual presentations where each individual therapist shared their unique spirituality provided a work environment with reflection built into it and was in itself a primary tool in building reflexivity into my clinical practice within the Centre.

Acknowledgements

The professional expertise gained during this practicum at the Family Enrichment Centre was second to none. It has since enriched the lives of many people to whom I have had the opportunity to provide my social work services.

Dr. Josie McKechnie, I offer to you my sincere gratitude, without you this practicum would not have been possible. Even though the doors of the Family Enrichment Centre were closed in 2015, the Centre continues to live on in the many people it has touched, including this social worker.

I would also like to acknowledge and thank Dr. Diana Coholic whose guidance and encouragement has enabled me to finally complete this paper.

Table of Contents

Introduction

As a student in the MSW program I chose to do practicum work rather then a thesis, as I have found experiential learning to be much more valuable in my quest for continued growth within my field. My BSW practicum work was based on my experience as a Health Services Coordinator at Independence Centre and Network (ICAN) and the Children's Aid Society of the Districts of Sudbury and Manitoulin. My experience within these settings peaked my interest in working toward my development as a clinical social worker, specifically in the area of psychotherapy. My interest in the psychological aspect of social work practice has deep roots, as previous to attaining my BSW I completed a General Bachelor of Arts degree with a major in psychology.

After obtaining my BSW, I started work with the Canadian Hearing Society (CHS) as a Connect Counsellor in March of 2005. In my role as a Connect Counsellor, I provided social work services that included provision of therapy to a client population that had some type of hearing loss. The CHS encouraged me to work toward the attainment of a Master of Social Work degree and my adventure within Laurentian University's MSW program began.

My work at CHS ended in the last half of 2010 and I took the opportunity to work on the development of my practicum proposal. The proposal was developed with the assistance of Dr. Josie McKechnie, Clinical Psychologist and Executive Director of the Family Enrichment Centre in Sudbury. I also worked on development of my proposal with the guidance of Dr. Daniel Cote and Dr. Diana

Coholic of Laurentian University's School of Social Work. My experiences at the Family Enrichment Centre enabled me to greatly expand my knowledge and abilities in the provision of psychotherapy within a social worker context.

The Practicum Setting

The practicum took place in the non-profit Family Enrichment Centre (FEC) of Sudbury. The FEC was founded in 1994 by Sister Noreen Muldoon, Sister Bonnie Chesser of The Sister's of St. Joseph and Evelyn Marcon. The FEC's Vision states, "Inspired by God's love and nurturing presence in the world, we are a centre that promotes healing of body, mind, heart and spirit" (www.familyenrichmentcentre.ca/_/index.html). The Mission statement reads, "In an environment characterized by a spirit of hospitality, trust and acceptance, the Family Enrichment Centre is committed to providing services that are grounded in compassion, respect, justice and care for all; are responsive to the vulnerable and those in need in our community within the limits of practical charity; and to promote healthy relationships" (www.familyenrichmentcentre.ca/_/index.html).

The agency had a community-based board of directors that the Executive Director of the agency reported to on a regular basis. The Centre received no government funding and was totally reliant on payment from people who used their services, donations from individuals and organizations, as well as fundraising activities. Depending on available funds, the agency promoted the use of a sliding fee scale for services that was determined by customer income. I worked with one

customer that paid as little as $5 per session. Counselling was both short and long term, often dependent on the client's funding source or ability to pay.

The service providers at the FEC had a variety of experiential/educational backgrounds. The Executive Director was a Clinical Psychologist as well as a Registered Nurse. The other service providers' educational background ranged from pastoral counselling, social work degrees (BSW and MSW), Masters level psychology degrees, theology degrees at the Masters level, Bachelor of Education degrees and Addiction Counselling diplomas. Several of the workers had been with the agency since its inception in 1994.

Although the agency was established by members of the Sisters of St Joseph as well as lay individuals from within the Roman Catholic Church, I found the environment to be one that was open to diversity of spiritual/religious beliefs. The agency's day-to-day practice allowed for unconditional acceptance of whoever came through their doors. There were limitations to this when it came to some services offered in a group format to the general public. An example of this was "Marriage Preparation Weekends." The weekend was open only to heterosexual couples but Catholic religious affiliation was not a prerequisite.

The Family Enrichment Centre occupied the entire 4th floor of the Roman Catholic Diocesan Centre in downtown Sudbury. The working atmosphere was highly supportive with a high level of professional expectations. There were staff meetings once a week for approximately two hours during an afternoon. The meetings often started with a spiritual component presented by a different staff member every time, followed by updates in agency policy and procedure, as well as

clinicians presenting difficult cases, and developing a plan of action for these cases through group discussion.

The majority of counsellors at the agency were on one-year contracts from April 1st to March 31st and had been with the agency for several years. The counsellors had some ability to decide workload as well as work hours. There were some counsellors whose primary work was not at the Family Enrichment Centre. Their primary work would be in other social service agencies. The counsellor who may come in during the evening to provide an anger management group is an example of a counsellor whose primary work was in another social service agency. The counsellors at the Family Enrichment Centre had a diversity of backgrounds with some specializing in the provision of psycho-educational groups, counselling of children, substance dependence issues, relationship difficulties and trauma. A standardized intake package was given to individuals and couples to complete immediately prior to their initial session, which was utilized as a starting point on work with clients as well as a measurement tool as therapy progressed.

Individuals working at the Family Enrichment Centre were definitely not there because of the financial compensation as the pay was low even for social work standards of pay. My impression of the agency was that every worker was very dedicated to the agency's Vision and Mission statement. The staff dedication to the Vision and Mission statement was not necessarily from only a Roman Catholic perspective as diversity was definitely welcomed. Limits to their level of diversity were only apparent when providing some services for the Roman Catholic diocese

such as the aforementioned example of the Marriage Preparation weekends for heterosexual couples marrying within their church (Catholic or Protestant).

Learning Objectives

My goals for the practicum were to learn ways of using clinical supervision effectively and to use it in part to examine the relationship between reflexivity and practice, and to learn different treatment modalities in my individual client work with a focus on the utilization of the strengths perspective.

Experientially, I entered the practicum with over five years of providing social work counselling and therapy to individuals and couples within a non-profit agency that depended on provincial funding, income generating activities and private donations. What I missed within this agency was an adequate amount of clinical supervision, hence my objective for the practicum was to utilize clinical supervision, specifically within the scope of work with individuals and couples. Reflexivity was also an important area for further development within this practicum setting as it is viewed as an aspect of personal and professional development that pulls everything together and promotes efficacy. The use of the word 'everything' means the use of self as the primary tool for service, the use of social work theory, and putting both of these together in the specific clinical applications.

To gain a more complete understanding of the stated goals of the practicum it is important to review some of the social work literature in order to provide a basis

of comparison with the practicum experience. In the next chapter I will review and discuss social work articles highlighting the strengths perspective as well as clinical supervision and reflexivity.

Chapter 1 - Literature Review

Within this literature review, articles describing the strengths perspective, supervision, and reflexivity will be examined. It was thought to utilize the strengths perspective (and any other perspective) to best advantage, clinical supervision and reflexivity need to be paired with it. A key part of my practicum experience was to work with clients in large part to recognize aspects of their strengths. I found in my previous counselling experiences that clients would often come focused on parts of themselves which they viewed as pathological. I worked with clients to deconstruct their pathology and within that process aimed to help clients to discover strengths they possessed in the midst of their pathology. These strengths would often turn out to be valuable tools in assisting a person to deal with issues presented in their counselling process.

To assist clients in doing this it was also important to reflect upon my own pathology and strengths as these have a tendency to interact with issues I am working on with clients. A large part of my ability to do this was utilizing reflexivity within the context of clinical supervision and by monitoring my thoughts and feelings when working with clients. In my experience as a counsellor, there always seem to be transference and counter-transference issues that reflexivity and supervision helped to highlight and utilize to best effect.

The importance that the strengths perspective, supervision, and reflexivity held within the practicum warrants a thorough review of the same. The following review will provide some important context of my practicum experience. The

review will provide somewhat of a basis on which to better understand the practicum experience.

The strengths perspective arose out of the need to expand outside the pathology perspective prevalent within the medical model. It does not eliminate the idea of pathology, however it does put it in its proper context by adding what is working. It is important to know what is working to enable one to look after the pathology with what is working well. In my experience as a social worker, I have found that individuals coming to see me often have a pretty good perspective of what is 'wrong' with them and have not put much thought into what is 'right' with them.

The primary reason for my focus on the strengths perspective is that in my clinical social work experience, it tends to work well in practice. Wood, Linley, Maltby, Kashdan and Hurling (2011) found "that people who reported greater use of their strengths developed greater levels of well-being over time" (p.17). I think the strengths perspective is a good match with reflexivity as one helps to build upon the other in an ongoing process of interaction between practice knowledge and the social work knowledge base for the benefit of the people we serve.

Reflexivity was an important part of this practicum experience because it highlights my own knowledge and experience in relation to my use of the strengths perspective in a clinical setting. Reflexivity has the ability to add to my own practical knowledge and to the social work knowledge bas as a whole. The concept of reflexivity for the purposes of this paper is one in which I "subject [my] own knowledge claims and practices to analysis…. [and] reflecting on why [I] might have

a particular emotional response to a situation" (Cruz 2016, p. 77 & 80) within the practice setting.

I think the importance of analysing my own knowledge claims and practices as well as emotional responses to situations is that it continually sharpens the primary tools within the practice setting. Ideally this reflexive practice provides for positive growth for social worker and client.

Supervision was very much complimentary to the strengths perspective and reflexivity in my practicum setting. Beddoe (2010) found that "supervisors rejected a surveillance role for supervision and supported the maintenance of a reflective space as crucial to effective practice" (p. 1279). Which was very much my thinking as well before starting this practicum and my thinking did not change upon its completion.

A Strengths Approach

The strengths perspective is one theory and approach that was part of my practicum experience with Family Enrichment Centre clients and colleagues. The agency was very much open to the use of this perspective, and, as it was an important part of the practicum experience, it is very necessary to include a review of some of the literature highlighting it. Several journal articles discussing the strengths perspective are reviewed and summarized as a basis for critiquing the practicum experience with the Family Enrichment Centre.

Dennis Saleebey, DSW, was a professor in the School of Social Welfare at the University of Kansas (Saleeby, 2001) and has been an instrumental person in promoting the strengths perspective for social work. The perspective has its roots in the empowerment focus within social work which began to re-emerge during the civil rights movement in America in the 1970's (Guo, & Tsui, 2010 p. 235). The strengths perspective was also an approach to social work practice that fit well with the "feminist responses to oppression and abuse" through the process of empowerment (Dietz, 2000, p. 375). The strengths perspective places the individual on an equal footing with the social worker by recognizing their expertise and deconstructing the abuse and oppression in a manner that illustrates their strength in the face of oppression and abuse. The strengths perspective does not focus on the problems or the powerlessness of service users but rather their strengths. Strength is found in resilience as well as in resistance and in strategies for one's survival despite adversity (Guo & Tsui, 2010, p. 239). In his article entitled "The Diagnostic Strengths Manual" Saleebey (2001) describes the DSM-IV's inability to measure someone's strengths.

> The DSM-IV's and long-standing diagnostic habits make it virtually impossible to consider or make an accounting of the assets, talents, capacities, knowledge, survival skills, personal virtues, or the environmental resources and cultural treasures such as healing rituals and celebrations of life transitions that a person might possess—despite or, in some cases, because of their difficulties and trauma. To ignore these things is to disregard the most important resources in helping a person recover, adapt to stressful

situations, confront environmental challenges, improve the quality of life, or simply adjust to or meliorate the effects of a devastating chronic condition" (p. 182).

Saleebey (2001) went as far as to suggest the DSM-IV add an axis VI. The axis would focus exclusively on a description of client strengths. The strengths can include "skills, talents, personal virtues and traits, interpersonal skills, interpersonal and environmental resources, cultural knowledge, family narratives, knowledge gained through adversity" (p. 184) and other life experiences. The inclusion of client strengths in this manner brings hope with specific direction into the life of someone weighed down by pathology.

Saleebey's Diagnostic Strengths Manual serves to highlight an important piece on the journey to wellness for clients that enter into a helping relationship with a social worker or any other helping professional. The minimization or even exclusion of client strengths can serve to elevate the specific helping profession's intellectual expertise at the expense of the expertise possessed by the client. The client's expertise is important because it is a large part of what they need to use in order to move forward. The clinical expertise is important in part because it can help the client to be more focused on how to more effectively utilize their expertise, to add to their expertise, and in many cases to validate the expertise they possess.

A recent review published by the Canadian Psychiatric Association entitled 'Overdiagnosis Problems in the DSM-IV and the New DSM-5: Can They Be Resolved by the Distressing Impairment Criterion?' written by Derek Bolton, PhD (2013) highlights the important connection between professional and client expertise. The

article acknowledged “Criticisms of psychiatry for overdiagnosing, for pathologizing normality” that go back to the 1960s (p.1). According to Bolton (2013) the weakness with the DSM is its primary focus on the expertise of clinicians (absolutely required) to the exclusion of the expertise of the diagnosed. The expertise (or strengths) of the person is not a focus of the DSM framework even though it could potentially be helpful whether or not a person has an official DSM-5 diagnosis. Development of a framework to more precisely measure an individual’s strengths (or expertise) can possibly strengthen the effectiveness of diagnostic and treatment tools such as the DSM-5.

An emphasis on a framework that can help to outline a client’s strengths is emphasized by Bolton (2013) and Saleebey (2001) as a key in the provision of more effective treatment of the mental health issues with which a client may be living. The feeling one often experiences receiving a diagnosis is often a sense of hopelessness. The addition of the very real strengths a person has in conjunction with their mental health condition can work toward providing hope and the motivation for individuals to discover ways that help them to move forward.

Geyer (2010) in his article “Strengths-Based Group Work With Alcohol Dependent Older Persons: Solution to an Age-Old Problem?” analyzed eight alcohol dependent men 55 years of age of older. Eight men were recruited for Geyer’s (2010) program and six stayed until program completion. There were 13 sessions that included educational components about issues connected to alcohol dependency that the men were able to utilize to build upon their own expertise.

Geyer (2010) found "that the strengths-based programme succeeded in enhancing respondents repertoire of strengths" (p.80).

Geyer's (2010) article described clinician knowledge combined with client knowledge can be complementary in nature. It is also likely that the strengths focus within Geyer's (2010) group helped to develop a rapport that was beneficial to the group members. The resulting enhancement of the group member's repertoire of strengths provided some evidence of the utility of the strengths perspective in the helping relationship. Bringing strengths into the group structure made it easier to approach the issues the men found difficult to confront.

Manthey, Knowles, Asher, and Wahab's (2011) article titled "Strengths-Based Practice and Motivation Interviewing" demonstrated that the lowering of tensions in the helping relationship makes it easier to deal with difficult subject matter. In this article, there is an attempt to demonstrate how motivational interviewing fits with the strengths perspective by "systematically comparing motivational interviewing with the strength based perspective" (pp. 126 -127). The comparison of the benefits of motivational interviewing and the strengths perspective tends to highlight the ability of the strengths perspective to complement different approaches to social work practice. This complementary nature allows the strengths perspective to be effectively utilized in many different situations and with different clientele.

Also providing evidence in this regard is Sherwood's 2009 article entitled "Clinical Assessment of Canadian Military Marriages." Sherwood examined "the impact of isolation and mandate on Canadian military marriages, and … illustrated the value of using the strengths view, systems theory and attachment theory when

assessing this population" (p. 332). A case example of a military marriage is used to evaluate these three assessment tools. Isolation is due to the "perpetual feeling of being physically, socially and psychologically separated" (p. 333) from the civilian population.

The military has an "exclusive mandate to protect and defend their country by non-peaceful means, and as sustaining combat readiness is no easy task, ordinary human beings must become personnel who can be called to war at any given time" (p. 333). To ask one to be ready for war at any point in time is a very tall order and one that does require great personal sacrifice of the soldier and their family. It can be very lonely not only for the soldier but the family as well.

> Sherwood (2009) suggested some authors have argued
>
> this [strengths perspective] view has also been accused of belittling the gravity of clients' problems by focusing away diagnosis.
>
> With all its limitations however, the strengths perspective is versatile enough to be used in conjunction with more sophisticated theories.
>
> Assessments incorporating this view are likely to leave an empowering effect on couple relationships (p. 335).

Sherwood (2009) recognized that it is important within the counselling relationship to not minimize client difficulties by exclusively or almost exclusively focusing on strengths because in doing so the message can be, "You have the ability, so what's the problem?" Acknowledgement of the difficulties as well as the strengths is of course necessary to develop a more realistic assessment of the situation and strategies in moving forward.

Sherwood (2009) recognized the value of using the strengths perspective when working with military couples. Her focus within this article was the advantage of pairing the perspective with other social work theories. She recognized that the military culture is also very different in some respects to civilian culture. Therefore, counsellors need to be careful on how the strengths perspective is utilized.

Douglas, McCarthy, and Serino (2014) described their development of a Strengths Based Practice Inventory to measure the degree strength-based modalities are utilized with child welfare workers with and without a social work degree. They found no significant difference between the workers with and without a social work degree in the utilization of strength-based practices. The inventory measure was adapted from a measure of how clients viewed their receipt of a strengths based service to a measure of how child welfare workers viewed their use of a strengths based service. It is thought that this model could prove particularly helpful in analysing the use of the strengths perspective by this social worker during his practicum at the Family Enrichment Centre.

Supervision and Reflexivity

The clinical practicum experience required the examination and interpretation of Reflexivity and Transference issues as a partial guide to maximizing my learning with the Family Enrichment Centre setting. The social worker as the primary instrument of service within this clinical setting called out for

a review of social work literature pertaining to reflexivity and transference. The strengths perspective is complementary to reflexive supervision as both include a focus on strengths and how to utilize them to best advantage. Reviews of the subsequent articles should provide a basis for discussion on how reflexivity and transference played out within the practicum setting.

Tsui (1997) traced the beginning of social work supervision in North America to Charity Organizations in the later part of the 19th century. At that time supervision was viewed primarily as an administrative function. The educational component to social work supervision started in the early 20th century. In the later part of the 20th century, supervision was leaning more toward a focus on quality control and accountability, especially to funding sources. Carroll (2009) divides social work supervision into "three major functions: (1) to support and help supervisees learn from their practice and to be effective in their work; (2) to build in an accountability factor so that their work is monitored and assessed; and, (3) to serve in an administrative capacity" (p. 218). Although the second and third functions are important my primary focus on supervision within the practicum setting was to learn and be more effective as a social worker practitioner using reflexivity.

Cruz, Gillingham, and Melendez (2007) defined reflexivity as "critical awareness by the practitioner in how he/she understands and engages with social problems; realizes that assumptions about social problems and those who experience them have ethical and practical consequences; and questions personal practice, knowledge and assumptions"(p.86). This definition of Cruz et al. (2007)

emphasized the use of myself within practice and that a heightened awareness of myself is central to providing individualized service to those I provided service to at FEC. It is a process that leaves one open to new learning; the teacher is both the service provider and the service receiver. It is humbling and exciting at the same time in the sense that it brings awareness that the more I learn the more I realize what I do not know, and the excitement is that there are always new discoveries around the corner.

The inclusion of reflexivity within my supervision was a good fit for me, as it allowed for a focus on the process of building better relationships with service users when applying the content (evidence-based theory) for more effective outcomes for service users. Evidence-based social work is important and was an important part of the work conducted at the FEC. It is often a requirement in order to secure resources, especially government funding. However, as Butler, Ford and Tregaskis (2007) have argued, "in the course of this search for clarity and scientifically measurable results social work practice is in danger of losing its meaning through a denial of the importance of process, and of building good-enough relationships with service users" (p. 294). I have found that relationships are often what makes the difference in 'successful' outcomes with service users and can make the difference in how well an evidence-based material works in practice.

Indeed, a small qualitative study of child protection workers in rural Australia, Carpenter, Webb, and Bostock (2013) argued that "supervision must refocus on the emotional impact of the work and use a reflective learning model to foster professional development" (p. 1844). Carpenter et al. (2013) found there is a

very limited evidence base to support the assumption many of us have about supervision. This assumption being that supervision produces improved workers and a higher quality of service outcomes. Carpenter et al. (2013) also found evidence that " supervision works best when it pays attention to task assistance, social and emotional support and a positive interpersonal relationship between supervisors and supervisees" (p. 1851). The evidence seems to point towards the importance of a focus on the processes used in social work supervision in order to obtain improved workers and a higher quality of service delivery.

Beddoe (2010) examined social work supervision from more of a process-oriented perspective. Beddoe (2010) interviewed six social workers with extensive experience in the provision of professional supervision over a number of years. The focus of the interviews was the impact of the "risk discourse" (p. 1279) of supervision for agencies more focused on risk avoidance then reflective practice. All six supervisors rejected the surveillance and favoured reflection as crucial to more effective outcomes in social work practice.

Beddoe (2010) touched upon the importance of the supervision process to "create a safe environment for people to discover their learning edge, build competence and utilise the energy generated by excitement and challenges in practice" (p. 1286). Supervision more focused on risk aversion tended to be more focused on outcomes, and Beddoe (2010) argued this can actually result in poorer outcomes as it can work to impede professional growth. Supervision that included process as a primary component examined aspects of relationship between a worker's professionalism and their organization functioning and expectations;

examined a worker's strengths in service provision; and then examined what they need to support them in their work. Beddoe (2010) acknowledged the need to assess risk, however not at the expense of the provision of a reflective supervision environment.

Schamess (2006) examined clinical supervision from the perspective of how supervision works and what is actually taking place in supervision. When these narratives are viewed in relation to one another, they reveal the enduring relational templates that shape supervisees' interactions with patients, supervisors and 'significant others.' Supervisory process that is attuned to pre-existing characterological templates not only improves supervisees' clinical effectiveness, but also enhances their relational capacity and overall ego functioning (p. 408). The supervisory experience described in the article included an examination of the strengths of the supervisee with the aim of building upon them to the benefit of clients. This process can be therapeutic to the supervisee, however, it is not therapy in that the aim is to maximize oneself as the primary tool in order to better provide counselling and therapy. The article also delved into transference issues within the supervisor-supervisee relationship and how transference can be a vehicle for growth. "Listening attentively for transference enactments in supervision enriches supervisory conversations and communicates empathetic interest…. such listening also enhances supervisees' capacity to relate therapeutically to their patients" (p. 424). The supervisor relationship is the primary tool in helping the supervisee to learn and to transfer this learning to their therapeutic relationship with clients.

White (2015) recognized that procedures established within social service agencies are there to minimize risk. It is important to minimize risk, but not to the point of minimizing or eliminating the use of reflexivity in social work practice. White (2015) acknowledged the importance of evidence-based practice as long as it does not "ignore the complexity of the different sorts of knowledge informing professional practice, as well as the role of reflection" (p. 258). Reflection within supervision can add an opportunity to understand, expand, and exercise our emotional intelligence so it can be utilized to good effect in practice situations.

White (2015) explained that in order to be a reflective social worker one has to also be a reflexive social worker. To be a reflective social worker critical analysis of one's use of reflection in action (reflexivity) is required. The ability to be reflective necessitates the use of reflexivity simply because if there were no reflexivity there would be nothing to reflect upon. "Reflexivity allows practitioners to locate themselves in the picture, to appreciate the influences on their knowledge and values and how all of this impacts on their practice" (p. 259). There seems to be an almost inexhaustible number of elements that can effect different situations, hence producing a learning curve that just keeps going. The idea that the more I know the more I realize what I do not know seems to fit here as every situation can be so different. White concluded in part that reflexivity in supervision does not work as well when implemented as an add on to what she calls procedural supervision. Reflexivity needs a focus all its own within supervision to be the most effective.

An important part of social work supervision is the emotional component. In our rational professional world emotions are often given second status to rational thought. Richard Ingram (2013) proposes a model that seeks to focus on both the emotional elements of practice as well as the process and practical issues relating to casework. This model recognized thought and emotion have direct impacts on one another. To examine social work practice as primarily a cognitive process leaves out a dynamic that directly effects the thought processes and one's ability to plan and accomplish specific goals. Ingram's (2013) model assists supervisors and supervisees gauge where they are when it comes to emotions and rationality. He suggested a circle illustrating the four possibilities in supervision. The first quadrant focused on the emotional elements of practice rather than on process and practical issues; the second quadrant placed an emphasis on a balance of the two; the third quadrant focused on the process and practical issues; and the fourth quadrant did not emphasis either approach. The model can be helpful in gauging where the supervisee and where the supervisor are in regard to emotion and rationality and help to work toward more of a balance that better equips the supervisee to reach practice goals.

One of the unique elements of supervision within the Family Enrichment Centre was the use of regular group peer supervision with other clinical staff working within the agency. In Golia and McGovern's (2015) article entitled "The Power of Peer Supervision in Clinical Training and Professional Development," peer supervision was defined "as any facilitated, planned or ad hoc interactions with colleagues of similar experience levels, …for the purposes of clinical training,

professional development, and mutual aid and affinity" (p. 635). Golia and McGovern outlined some advantages of peer supervision such as normalizing emotions, better ability to evaluate and use different approaches, is often less intimidating, and works to develop professional bonds that can in themselves be useful in dealing with a variety of situations. The article breaks down the approach to peer supervision into three categories: facilitated peer supervision, planned peer supervision and ad hoc peer supervision (pp. 636-638).

The breakdown of approaches can be helpful in evaluating this social worker's practicum supervision experience, as peer supervision was the most frequent type of supervision accessed during the practicum placement. Golia and McGovern (2015) describe facilitated peer supervision as being lead by a clinical supervisor who encourages participation of the peers (p. 638); planned peer supervision is more egalitarian then the former, made up of peers with comparable experience and expertise and can take place within or outside of the agency (p.639); and ad hoc peer supervision is just what its name implies, as it is not planned and occurs in a spontaneous manner within the clinical setting (p.640).

Berzoff and Drisko (2015) discussed supervision and psychodynamic theory. Supervision and psychodynamic practice were important components of this practicum experience as the settings' primary service was counselling and psychotherapy. Berzoff and Drisko (2015) examined the tendency toward a de-emphasis on clinical supervision and psychodynamic practice in social work: "In public clinical practice, productivity demands are very high. Yet supervision for clinicians, especially for beginning clinicians, is less frequent, is increasingly

administrative in focus with the focus on documentation and risk reduction" (p.266). This statement upon further examination may have some direct relevance to the provision of clinical social work services within the practicum setting at the Family Enrichment Centre, which will be covered in more depth within the next two chapters. The following chapters discuss my application and analysis of the strengths-based perspective as well as my use of reflexivity and supervisory feedback within the practicum setting.

Chapter 2 - Application and Analysis of Strengths-Based Perspective in Practice

The Family Enrichment Centre's receptionist was usually the first point of contact between the potential client and the Centre. The contact was typically over the phone (occasionally face to face contact) by the receptionist in the front office. The initial contact information can offer loads of information on potential areas of exploration of a client's strengths. If a client has had a depression for a length of time, for instance, the question that might arise is what factors helped the client survive the depression up to this point in time. The information gleaned at the start often holds at least some of the answers to what these strength factors are, or could be, and provides direction for further exploration.

The information collected on the intake form was the typical date, name, address, and other contact information. It also included DOB, age, sex, doctor, medication, employer, occupation, education, religion, emergency contact, marital status and years married, number of children, referral source, previous counselling (when and where), any previous FEC counselling and name of counsellor, who presently seeing (psychiatrist, counsellor, etc…), best time for appointment and the reason for referral. The receptionist would then assign the intake form to a specific counsellor. That counsellor would indicate if he or she could take this person on or not. If there was no counsellor available, the client would be placed on a waiting list and be contacted once there was an opening.

At the intake, the fee arrangement would also be discussed. If the client had an Employee Assistance Plan details of the plan were taken that usually included number of sessions allowed, were there co-pay provisions, and type of therapist covered under the plan. For referrals without an EAP or referrals requiring more then the maximum number of sessions provided under their plan, the level of income would determine the fee paid per session.

The fee was based on a sliding scale and there was always a minimum amount of payment required, for example, if someone made less then $25,000 a year they would be eligible for what was known as Low Income Cut Off (LICO). The LICO rate would be based upon the Centre's ability to subsidize counselling sessions. If the agency was limited in their ability to subsidize, the LICO rate would be $50 per session. I had the experience of working with an individual who paid $5.00 per session because of low income. The ability for the Centre to subsidize referrals was based on funds donated for that specific purpose. Sometimes the agency was not able to go below $50 per session for their Low Income Cut Off (LICO) for new clients, but would maintain existing fee subsidies with active clients. The intake was the agency's method of maintaining a level of consistency that allowed them to keep track administratively of past, current and waiting list clients and manage costs and income to allow the agency to continue functioning. The Centre received no government funding at all.

Upon accepting a new client, the counsellor contacted the client to arrange an initial session. The referral was typically asked to arrive at least 15 minutes early in order to complete information to be reviewed with the counsellor in the initial

session. One of the primary reasons for the client coming in early to complete the information prior to session was to be maximize client-counsellor time during sessions.

The information provided by clients at this stage included relevant psychosocial information; a brief history of the presenting problem; GAF (Global Assessment of Functioning); stage of change (precontemplative, contemplative, prepared, action or maintenance); actions to support goals; family genogram; and risk assessment. There was also a 'Pre-assessment (Outcome Measures)' and 'WHO-Five Well-Being Index'. If the score on the WHO-Five Well-Being Index (Appendix C) was at or above a specific score (13) the client was asked to complete a MDI-10 depression screen (Appendix E). The information did tend to focus on pathology in an attempt to define the problem(s) and was vey helpful in this regard. There were also measures prescribed after a specific number of sessions that gauged the level of client pathology (specifically depression inventories, anxiety inventories and global assessment of function measures).

The process for defining the client's difficulties, established by the Family Enrichment Centre, was important. Bolton (2013) recognized the absolute necessity of clinician and client knowledge and argued that the initial assessment was a means of setting a baseline to use as a starting point. The knowledge of the clinician in defining the client's pathology is absolutely necessary to be able to assist in utilizing the client's strengths to best effects. The assessment process is also reliant upon client knowledge to better define their unique situation.

I found that the strengths clients possessed were often very present with the 'pathologies' they were presenting. For example, the pathology might be a pattern of thinking, feeling and behaving with its genesis traced back to the family of origin. The very pattern presented played an important role in the ability to cope and even survive the difficulties experienced within the family of origin. Of course, the patterns were developed out of whatever the child could bring draw from their cognitive, emotional and physical abilities at the time. What I found was important was these patterns illustrated the resilience the individual had, at the time, to cope and survive. In other words, present day pathology often played an important role in survival and coping at some point in the past.

What was once considered a weakness can now be seen to have some qualities of strength, at least from when it was first utilized. Viewing it this manner often opened the door to approaching their 'pathology' in a much more constructive manner. It also opened the door to exploring strengths they possess at present that can now be used as a baseline to look after cognition, emotions and behaviour that played a key role during the earlier difficult period in their life even though the 'pathology' does not fit so well with their present life circumstances. The new narrative validates the cognition, emotion and behaviour triggered by present day events, even though it adds emotional intensity to these events. The narrative would include validation of the triggered emotional pattern as it is often connected in some manner to difficult life events. The pattern deserves to be treated with respect and compassion (though recognizing that does not necessarily mean following the behaviour in that pattern), and recognized as a strength at the time

because of its connection to helping cope with difficult life event(s), even though the pattern is often dysfunctional at present. This recognition allows the client to then utilize present day strengths in a manner that can help to accept and ride through the cognitions and emotions triggered from an earlier time in their life (without following them behaviourally).

An example of this might be a man who perceived as a young boy that when his mother was displeased with him, he was in danger of being abandoned by her. In a young boy, abandonment by his mother would likely be tremendously frightening, so the boy would do whatever he could as a boy to neutralize this perceived threat. Of course the boy would only be able to utilize a boy's cognitive functions, emotional functions and behavioural functions. As a man he may experience specific perceived stressful life events that trigger a similar cognitive/ emotional/behavioural response that he experienced as a boy when feeling like he was going to be abandoned by his mother. As a boy, the response would be a form of acting out and as an adult the acting out might be an alcoholic binge with out of character behaviour such as fighting. The response does not make sense from an adult's perspective, however, very much makes sense from a boy's perspective believing he is in danger of abandonment by his mother. The compassion comes into play by recognizing that the boy found a way to make it through these difficult experiences with a boy's way of thinking, feeling and behaving, which is a definite strength. A caring adult might respond to the boy by accepting the boy's thoughts and feelings, then leading the boy in a different direction behaviourally in a caring manner. One can validate a feeling without supporting its manifestation.

The man recognizing the pattern described above has a narrative that fits his past and present day experiences in a manner that defines his inherent strengths. It is important to acknowledge the strengths present in a boy experiencing a perceived threat of abandonment and the strengths of a man able to accept this boy in a loving and caring manner, enabling him to ride through emotional intensity to get to a more functional behavioural response to the present triggering life situation.

The structure of the counselling assessments and screening at the Family Enrichment Centre allowed for a rich exploration of client dynamics that could be used to recognize and examine very real strengths in conjunction with pathology. I found that this really helped to empower clients and build motivation to view and look after themselves in a much more constructive (caring and compassionate) manner.

The Family Enrichment Centre practicum experience had some built in routines that would help a social worker to focus on a strengths perspective. Saleebey (2001) mentioned healing rituals and celebrations of life transitions that a person might possess. At the Family Enrichment Centre, there would be group clinical consultation with other clinicians every second Thursday afternoon. One staff person would be encouraged to present a spiritual exercise and guide their co-workers through it. The spiritual exercise did not need to be from any particular religious perspective although it could be. These exercises were representative of co-workers' strengths that helped to guide them in their day-to-day life with its natural highs and lows.

The spiritual exercise would be based upon a central belief or philosophy that plays a part in most aspects of one's life. I recall sharing my belief in the Great Commandment within Christianity: love God with all your heart, soul, mind, and strength and love your neighbour as yourself (Matthew 22:35-40). Love includes compassion, kindness, forgiveness, patience and humility among other things (1 Corinthians 13). I shared an example from my personal life and how it also has application within my professional life, especially in developing rapport with clients.

My father was a WWII veteran and carried the wounds from his war experiences in a way that very much affected his behaviour in his marriage and with his children, in sometimes very traumatic ways. The story I shared in regard to my father was that by following the commands mentioned above, it had a profound impact on my relationship with my father and hence with aspects of myself that were very similar to his characteristics. I had primarily negative, even traumatic experiences, with my father growing up, almost always experiencing a sense of fear when he was around. These experiences still very much impact my daily life. I chose to actively forgive my father, which did not always match what I was feeling. Forgiveness opened me up to see my father's wounds and allowed me to view the beauty in those wounded parts of my father and see his best qualities, his sensitivity and his love of nature and for children. I could relate to some of his wounds as I had some very similar ones and some personality characteristics that were similar to his own that I previously viewed in a negative light. All of this brought some connection with my father I did not previously have to any great degree. The connection was significant in how it affected my father's last years and how it affected me personally

and professionally. The lesson was that the love described above brought connection, self-acceptance, and became a guiding force in my life that has taught me how to develop rapport with clients that is so important in helping them to move forward.

These exercises brought to awareness on a regular basis one's own healing rituals and celebrations of life and those of other co-workers. I found that this awareness was transferred to counselling and psychotherapy work with clients. There were the different pathologies that the intake assessment would need to highlight in order to gain an understanding of what clients want to work on. The healing rituals and celebrations of life shared by co-workers seemed to help me look for these rituals and celebrations with clients in session. They were often found to be areas of strength that made a difference in their ability to cope with whatever difficulty they were facing. Even when clients used these aspects of themselves in negative narratives, my heightened awareness allowed for more exploration of belief systems tied into healing rituals and celebrations of life. Following what the clients brought into session in this regard could often help them to change the narrative of their life situation in a manner that would help them to also focus on the very real strengths they possess.

In my practicum experience, an example of this change was with a single middle aged individual that was dealing with some significant suffering due to abuse experienced as a teenager and the subsequent pedophilial desires stemming from the type of abuse experienced. The client viewed the desires as pathological. What I was able to do was to help explore the different aspects of forgiveness, kindness,

and love within this client's belief system. It did not bring a miracle cure for the client, but it did help someone the client, after suffering for many years to gradually transform the condemnation in the pain and suffering into forgiveness, kindness and love.

The client's religious tradition, which condemns abuse, kept the client from acting out the thoughts and feelings stemming from the abuse the client experienced, but caused the client to feel condemned for experiencing the thoughts and feelings as they tempted them to act in an abusive manner. This thinking created a cyclical pattern: resistance to acting on the 'bad' thoughts and then feelings reinforcing the belief that the client was a bad person. The feeling of 'badness' was persistent even though there was plenty of evidence to show the client was not 'bad.' Whenever the condemning narrative came up they learned not to fight it but recognize it as the inner hurt teenager. They were able to see that the 'bad' thoughts and feelings were indicative of the cognitive/emotional presence of a very hurt teenager (the client) that required the love of an adult (the client) and to begin to include the hurt teenager within their cognitive/emotional narrative. The client would extend that compassion to someone with the same problem who required comforting. The thoughts and feelings eventually became less threatening and became viewed as an opportunity to look after the hurt teenager, which aligned with the client's religious tradition.

Strength therapy also helped the client to begin to separate the thoughts, feelings, and behaviour associated with their experience of abuse, changing the thinking pattern from feeling deserving of condemnation to feeling deserving of the

forgiveness, kindness and love that is very much a central part of the client's belief system as well. Strength therapy helped to bring self-compassion into the client's pain and suffering. Boundaries that were a part of the client's tradition helped to keep the client from crossing the line, so to speak, legally and in relationships. Therapy reconnected the client with the forgiving, kind and loving aspects of the client's belief system.

The focus with this individual was on what Bolton (2013) described as the client's expertise. My role was to help the client to explore, highlight and build upon the expertise to develop better coping skills. The individual was already very aware of the 'pathologies,' but needed assistance to recognize the expertise (strength) already possessed to look after these 'pathologies' well.

The regular spiritual exercises experienced at the Family Enrichment Centre within the group of co-workers helped to keep the focus on strength within the midst of the many different life experiences, including the 'pathologies' that co-workers and other individuals experience within their life journey. As Bolton (2013) emphasized, the addition of the very real strengths a person has in conjunction with their mental health condition can work toward providing hope and the motivation for individuals to discover ways that help them to move forward.

Geyer (2010) suggested clinician knowledge with client knowledge could be complementary in nature. To expand upon this, I would add that clinician knowledge is often most useful when it works to help uncover and build upon the existing self-knowledge clients bring to the sessions. It is client knowledge that is the most important for every day life as the therapist is usually only around for an

hour or so once a week. The remaining time within the week relies upon expertise the client possesses to chart a path forward.

Motivational interviewing was something that was encouraged at the Family Enrichment Centre. With their very limited finances, FEC made it a priority to send a group of staff to a refresher on motivational interviewing put on by the Canadian Mental Health Association. Manthey, Knowles, Asher, and Wahab (2011) described the strengths-based perspective as hope inducing and the motivational interviewing relationship as one that facilitates hope, confidence and motivation for change. Motivational interviewing, like the strength-based perspective, explores what the clients bring to the table in relation to the difficulties they face. The two are a very good fit in empowering clients to move forward in their lives. The focus on motivational interviewing naturally inclined myself and co-workers to apply the strengths-based approaches to those who came to us for service.

I utilized motivational interviewing with clients at FEC when assessing process of change. A prime example was my work with a client who had an eating disorder. The disorder was very much a part of everyday cognitive, emotional and behavioural life that the client had developed strategies to manage well. The client was in a long-term relationship in which there was a need for the client to be more self-assertive. This need for self-assertiveness was seemingly in a direct contradiction to the emotions associated with their eating disorder.

I started to work with this individual during my practicum in 2011 and continued my work with the client until 2013. Geller and Dunn (2011) talked about the importance of warmth and empathy with Socratic questions and reflective

listening, a hallmark of motivational interviewing. I found that patience was also a key ingredient as movement from pre-contemplation to action and then maintaining was a back and fourth process over the two years of work with this individual. The pace at which we were able to move had to be very much respected or the individual would have withdrawn from therapy.

Paul and Elder (2007) define Socratic questioning as:

> [The] "disciplined questioning that can be used to pursue thought in many directions and for many purposes: to explore complex ideas, to get to the truth of things, to open up issues and problems, to uncover assumptions, to analyse concepts, to distinguish what is known from what is not known, and to follow out logical implications of thought" (p. 17).

The disciplined questioning has proved very helpful in digging below the surface of client narratives and discovering attributes they may have interpreted in a manner that was at least incomplete. Socratic questioning allowed me to help uncover strengths in the midst of what was often considered by clients to be dysfunction, weakness, or a flaw within themselves.

Due to motivational interviewing having built within it the recognition of client strengths, I was able to gradually help the client move toward using these strengths within their long-term relationship and other familial relationships. A hallmark of motivational interviewing is warmth, reflective listening and Socratic questioning, which I consistently utilized throughout the therapy. The consistency was crucial to developing a rapport that allowed the client to work well enough to gradually move forward over the two years. The technique of the motivational

interviewing continually reinforced the sense of safety and security required to help this person to gradually move forward. The client, at the end of therapy, was able to recognize the journey and see the better balanced relationships with others (partner, family, friends, etc…).

The FEC tools with motivational interviewing were especially helpful when working with family of origin issues that were of significant emotional impact to individuals. These tools allowed for the exploration about family of origin dynamics up to the present day family dynamics. In situations where the dynamics were perceived as threatening in childhood, there were thoughts, emotions and behaviours used during this period that helped the child to cope. In the present, when triggered, these clients experienced similar intensity of emotion to what they experienced in the earlier period of their life. The clients would often recognize the triggered thoughts, emotions and behaviours to be dysfunctional and wish they would just go away. There was often a client-generated narrative that would include a negative view of these thoughts, feelings, and emotions. The dysfunction (or pathology) of the present day thought, emotion and behaviour patterns from an earlier time in life was often the primary theme. The strengths perspective was used in these situations to help to add to the narrative parts that were missing.

In order to get to the point of the client adding to their narrative, I would establish a solid rapport with the client. I did this initially by using reflective listening to gain a thorough understanding of their perspective on the reason they came into counselling in the first place (their dysfunction). Once the client agreed I had obtained a good understanding of their situation, I would start using Socratic

questioning. This type of questioning was important as it worked to look at the strengths within their dysfunction from the perspective of a person at the age they experienced what they perceived as the origins of their difficulties. This childlike questioning would reduce the critical adult perspective and open up the client to possible perspectives from a person at the age when they had the intense emotional experience. More perspectives, more possibilities; more possibilities, more hope; more hope, more motivation to change; more change, more success.

An exploration of the strengths the person possesses in the present were important at this point, because they are what would be utilized to help process their thoughts, feelings and emotions from the earlier life experiences that are triggered in present day experiences. To help with processing these thoughts, feelings and emotions, present day triggers would be explored. Then there would be a discussion of strategies to best apply their strengths to the triggering situation. This process would continue until the client felt they had moved forward enough to work without my assistance and feedback.

I had the opportunity to work with a single parent for whom there was no obvious point of origin for the triggered present day thoughts, emotions, and behaviours. The person did not come from a family that was abusive, yet there were these triggers. There were several sessions spent exploring the origin of the behaviour, and it was eventually discovered that the intense experience was at a period of time in early childhood. The client was a very sensitive person and had a deep-seated fear of parental abandonment whenever a parent was displeased. As a

parent, this client was able to quickly catch on to strategies (strengths as a parent) to manage triggering situations.

The strengths perspective was very important in this regard because it brought a more balanced perspective of personal dynamics. It did not dismiss the dysfunction caused in the present. It did, however, provide a means to develop a way of recognizing and hence looking after the thoughts, emotions, and behaviour. This perspective required a clients understand their way of thinking at the developmental age at the time of their perceived childhood traumas. The understanding allowed them to judge their present dynamics in a manner that fit the developmental age in which they experienced their perceived trauma. The understanding helped to develop a narrative that fit how a child at that age could best cope with a situation. The thoughts, emotions and behaviour at the age they experienced the perceived traumas were then examined from the strengths perspective. Forde and Duvvury (2016) found it was important for male survivors of childhood sexual abuse to have a "trusting relationship with their counsellor as integral to the experience of…. emotional exploration and expression… central to the recovery process" (p. 6). This exploration involves connecting to parts of oneself from which one would usually want distance -- the child that experienced the abuse. In childhood sexual abuse, the abused child is exactly the part one needs to learn to connect with and look after. In connecting to the inner child who experienced the abuse, they then can come to terms with pushing away that part of themselves.

Once the childhood view was established, the next role for the strengths perspective was to go over the evidence of present day strengths as an adult. This

process would lead to clients being introduced to the idea of how the strengths they possess as an adult can be used to meet the needs of the childlike manner of thinking, feeling and behaving that is being triggered in the present. What does a child need when experiencing intense emotions, and how can a loving adult help to look after a child to look after the emotions?

The examination of strengths from childhood and adult perspectives also has a direct effect on learning and applying emotional regulation. A more balanced narrative invites the concept of self-compassion and kindness that enables clients to better tolerate the ride through very intense emotions. The expanded narrative allows clients to respond to the needs associated with their present day experiences. The needs would usually be twofold: the latent needs generated by the experience of a perceived threat (safety, comfort, etc) in the past and needs generated by the situation in the present..

Forde and Duvvury (2016) described how a man "was enabled to forgive himself by imagining his son being in the same position he was in as a child" (p. 6). My work at the FEC often involved helping clients find a way to connect with their inner child and, if they were parents they could often connect with imagining their child and, if they were parents, they could often connect with imagining their child being in the same position as they were as a child. They would then be encouraged to explore how they, as loving parents, would look after their child if the child was in the same position they were as a child. There were many different components to this work.

One component involved recognizing that the strategies used as a child to survive their ordeal were often heroic, especially due to limited childhood abilities (e.g., knowledge, emotional and physical development, power differential, life experiences, etc.). Another component would be the recognition of some of the reasons they might push away or block this inner child from receiving their support. Under stress, an adult may experience cognitive, emotional and behavioural patterns that match a stressful experience from childhood. The cognitive, emotional and behavioural pattern from childhood would not fit well with the stressful event they are currently experiencing. This mismatch creates even more distress and the adult would want to just push away the very inconvenient cognition, emotions and behaviour. Pushing away the inconvenient cognition, emotions and behaviour causes the child within them, who experienced the stressful life event and coped in the only way the child knew how, to be rejected and pushed away by the adult. By recognizing this rejection, the adult can connect on an emotional level with the child within who suffered the trauma. How would you, in a loving manner, approach a scared, angry, and very hurt child? The answer would be to use the strengths you now possess as an adult to connect with that child.

By acknowledging the trigger and releasing that emotional intensity, the clients will have a clearer understanding of the emotional intensity associated with their present day experience, and know how to look after it in a manner that is caring and compassionate, which will in turn allow them to then feel safe enough to ride through the emotions instead of acting upon them. In the next chapter, I will discuss my use of the strengths perspective in relation to my practicum experience

of utilizing reflexivity and clinical supervision. They both proved to be valuable tools within the practicum in advancing my individual and couple work with adult clients.

Chapter 3 - Application and Analysis of Reflexive Practice / Use of Supervision

In order to provide a basis for analysis of reflexive practice or use of supervision during the practicum at the Family Enrichment Centre, a description of the supervision at the Centre will be provided.

Initial practicum work with the FEC supervisor began with an introduction to other agency staff and how and where to access agency information on agency procedures established for working with clients from initial intake to the completion of work with clients. A description of the primary procedures involved with work with clients was previously provided in this report in the analysis section of the strengths-based perspective. Time was given to review these procedures and a subsequent meeting was set up, where five individual referrals were assigned, and other possible work within the agency was discussed. The other work included participation in their established anger management group as a participant as well as co-facilitation of a Marriage Preparation weekend for heterosexual couples.

The time available for individual face-to-face supervision at the Family Enrichment Centre was sometimes limited due to the demands on the supervisor for providing direct client service and the many administrative demands of a not-for-profit agency. The Family Enrichment Centre depended on many different sources of funding, including insurance companies offering Employee Assistance Programs (EAP). The EAPs all had differing requirements for service, including who provided the service, time allowed, and service modality. This complexity did not directly

impact this social worker, as the requirement for all of these EAP programs was a clinician at least at the Masters level. During clinical group consultation, there would need to be very novel approaches to provide the service the client required that matched what the EAP insurer required. At times there was a need to help the client find another community service that was publically or privately funded because their EAP did not provide for their specific needs. Employers would sometimes contribute resources on top of what their EAP insurer provided. Working through the details of specific cases with insurers often involved the Executive Director and the clinician discussing ways to meet needs within the confines of different EAPs.

The funds offered for service through EAP seemed to be taking on increasing importance. In the Family Enrichment Centre's 2010 Annual Report, their Treasurer reported, "We have had to draw from the reserve fund again this year to meet the operation's costs. Drawing of reserve funds, coupled with very low interest rates, puts the reserve fund in jeopardy. …. We must continue to find the delicate balance of providing the right amount of service while ensuring fiscal responsibility" (2010). The resources required for the agency to follow their mandate seemed to be constantly under pressure. In spite of these challenges, very creative means were utilized to make sure reflexivity in practice was an important component of providing a quality service.

The supportive atmosphere this social worker experienced within the Family Enrichment Centre allowed him to be comfortable enough to bring up specific transference and countertransference issues with the clinical supervisor, and she

took the time to discuss the issues in depth. The issue of transference and countertransference was discussed in an open manner. She stated that the transference and countertransference issues I brought up illustrated that I was very sensitive to their presence in my work with clients. The awareness and concern I expressed about the transference and countertransference issues were considered strengths that did not adversely affect my work with clients, in fact quite the opposite.

The take on transference and countertransference in my therapeutic relationship with clients at FEC is one in which they both can work toward meeting client needs within therapy. I consider myself in relationship with my client as the primary tools in the counselling relationship. The concept of transference and countertransference in my use of the terms is the sum total of the impact interactions the social worker has on their client and vice versa. The goal of my use of transference and countertransference within the FEC practicum was growth for the client and for myself as a social worker. The use of supervision and reflexivity to understand these dynamics was a learning goal for my practicum experience.

Scaeffer (2014) conceptualizes the importance of understanding these dynamics and their potential for client and social worker growth when understood by the social work practitioner. "Transference and countertransference are essential in a relational practice where the patient's and the therapist's narratives are the principal material for change in the patient's functioning" (p. 15). The importance of understanding self in relation to the client cannot be overstated here and the ability to use the experience of other clinical experts proved to be helpful to

this end. My understanding of transference and countertransference within my practicum setting is the mutual effect that the interaction of both has on each other and how to use that to best advantage for the client.

There was one experience I remember with my clinical supervisor that proved very helpful in my becoming more comfortable with the mutual dynamic of transference and countertransference. I was describing to her the emotional impact I was experiencing with one particular client (I don't even remember the specifics of the experience, just the response she gave to me). I was very uncomfortable with the thoughts and emotions this client was triggering in me. My primary woory was that my reaction could potentially effect the outcome of service provided to this client in a negative manner. The supervisor explored this concern in-depth with me and concluded that my apprehension actually demonstrated a keen awareness of transference and countertransference issues with this client and thus had great potential to work out for the benefit of the client.

This supervision lesson sticks with me to this day many years later, and has proved to be beneficial to clients and worked to greatly expand my own practice knowledge. What sticks with me is not the memory of the specifics of the situation with the client (as I have no memory of the specifics), but rather the emotional intensity that I was experiencing. It was the discussion with the supervisor in regard to my own emotions that stuck with me. It taught me that it was okay for me to experience emotional intensity when working with a client. Not only was it okay, it is a useful way to gain more working knowledge of the primary tool I utilize within the helping relationship, myself and to continually make new discoveries in

this regard. Increasing my self-knowledge in this manner greatly assists me to work with clients to discover their own patterns of thinking, feeling and behaving. Their self- discovery can enable them to utilize their new self-knowledge in a manner that provides direct benefit to them.

White (2015) concluded that reflexivity in supervision does not work as well when used as an add on to what she calls procedural supervision. I found the supervisory experience at the Family Enrichment Centre to be very reflective in nature. Procedural issues were organized in such a fashion that they did not need to be the central part of the supervisory process, which made room for the supervisor to be attentive to my specific needs in my development as a clinical social worker and she found creative ways to help me to meet these needs even though her time was limited.

One avenue she used was to recommend that I participate in an inhouse 8-week anger management psycho-educational group. The group facilitator allowed me to be a part of the group only if I came in as a participant. Different strategies for recognizing and looking after one's anger were discussed within the group in depth. I do not think individual supervision alone within this practicum setting would have provided as much reflexivity as my participation in supervisor directed activities such as the anger management group, even if the clinical supervisor had more time to meet individually.

For instance, the anger management group had a huge affect in my ability to work with the individual clients to whom I was assigned. White (2015) acknowledged the importance of evidence-based practice as long as it does not

"ignore the complexity of the different sorts of knowledge informing professional knowledge, as well as the role of reflection" (p. 258). My anger management group participation was an excellent vehicle in providing evidence based knowledge partnered with mandatory reflexivity. The experience within the group proved particularly helpful when a young person came in to see me (probably somewhat high on drugs).

This person had a history of physical abuse from the family of origin and learned to react in a fighting manner when feeling triggered by present day events. During session, the person said to me "I feel like punching you in the face". The understanding the anger group had given me on an experiential level proved invaluable in this interaction. I was able to recognize my own emotions in this situation and look after them to the point that I was able to focus intently on helping this client ride through his anger until he was calm and relaxed. This ability then allowed me to intently observe for clues about the hurt this individual was experiencing. Instead of responding to the anger, I was able to recognize and respond to the hurt that was behind the anger in a manner that was validating and comforting. My reaction allowed the client to leave my office stating, "I feel much more relaxed now," and to actually thank me. My ability to respond in the most helpful way within this particular session was directly connected to my experience as a participant within the anger management group. The clinical supervisor's ability to recognize the benefits the anger management group could provide in developing a reflective practice orientation proved to be of great benefit for myself personally and for my clients, as illustrated in the case example described above.

Moreover, what I found stood out about my experience in the anger management group was the fact that anger was brought on by a thought (or interpretation) of an experience that somehow triggered pain or discomfort. By interrupting the thought process and/or providing empathy to the suffering, I could interrupt the anger so that it did not reach a point of no return, an explosive anger reaction. In the case above, the explosive anger reaction would have been the client attempting to punch me in the face. During this interaction I did not react to the client's anger except to listen to clues about the pain's origin and find opportunities to offer some sympathy for this pain. To react to the anger would have intensified the anger. I did have some previous interaction with this client and knew of the paternal physical abuse. The offering of comfort to the client's pain enabled me to help this person ride through a painful experience and not act out.

There were other experiences that illustrated to me that my clinical supervisor was very attentive to helping me to build upon my existing strengths through reflexivity. My supervisor knew about my history within my family of origin and used that knowledge to help me in my work with clients. The request for me to co-facilitate a Marriage Preparation weekend was something that helped me to face the thoughts and feelings family of origin issues brought up in a safe environment. If the thoughts and feelings were too much for me, my supervisor as co-facilitator was there to step in. The knowledge that she was there for me allowed me to feel safe enough to allow myself to process my own thoughts and feelings as I was assisting in facilitating segments of the weekend.

The marriage preparation weekend was psycho-educational in nature and topics covered included communication styles, various aspects of family relationship dynamics, beliefs, and practicalities within any marriage relationship (e.g. money management). I was able to assist with the co-facilitation in the communication styles component as well as inter-family relationships.

I have to admit there were components of the weekend that did trigger memories of not so pleasant dynamics from within my family of origin. However, these were brought out in the open and self examined from a more logical rather than emotional perspective, as I needed to be present as a co-facilitator. The added perspective helped to expand my emotional responses in a manner that was more inclusive of the range of mixed emotions that are a part of any relationship, especially family relationships. It was one thing to understand all of this on an intellectual level but the co-facilitation allowed the understanding to expand on a more experiential level that improved my ability to work with clients within a therapeutic setting. It experientially gave me more permission to experience thoughts and feelings within a therapeutic setting with clients, confident that I could process them as well as attend to whatever the client was presenting.

Another creative use of supervision and reflexivity within the Family Enrichment Centre was the regular group consultations held once every two weeks with all the employees who provided therapy and counselling sessions. The consultations encouraged the bringing together of evidence based practice as well as reflexivity to better serve people coming to the Family Enrichment Centre for

service. It proved to be of vital importance to me as I had a case that would probably have proved difficult for many social work practitioners.

The case I am referring to was with a middle aged adult who had experienced persistent mental health difficulties over several decades. I had seen this client for three or four times before the client sought treatment in the hospital. I thought I had developed a good rapport with this client and had a good idea of the intensity of the difficulties being currently experienced. I spoke with this client while in hospital and the client agreed to see me immediately after discharge from hospital. The client had a history of attempting suicide and was well experienced with the inner workings of the public mental health system. I was utilizing the group consultations with colleagues within the Family Enrichment Centre who had experience with this client.

A few days after I had spoken with the client, I was informed by my clinical supervisor the client was self-discharged from the hospital and had died by suicide. The group consultation, individual supervision and clinical supervisor all worked together to create an environment that encouraged reflexivity and was important in helping me to work through this very difficult case.

In such a case an agency might be tempted to focusing on minimizing risk of liability. The Family Enrichment Centre took care of this risk in part by being open to attending to the needs of surviving family and by having in place policies and procedures that created a safe environment for all. Family Enrichment Centre representatives had met with family and offered their condolences and offered support if wanted or needed. The policies and procedures in place included a

review of the case by the Executive Director to examine if best practices were followed in this particular situation. These procedures also included transparency when dealing with difficult situations and a focus on the well being of the family and the social workers who had worked with the family. I participated in group consultation and informal consultation with colleagues who had worked with this client prior to me during the time I had worked with this client. The support offered by the Family Enrichment Centre on a professional and personal level was what helped me to move forward in continuing to provide clinical social work services. The sister of the client that died by suicide even wrote this social worker a card describing the client's decades of struggles and how the client had communicated with her how much of a rapport was developed with this social worker in a relatively short amount of time.

Ellis and Patel (2012) found that "the death of a client by suicide is an emotional, sometimes even traumatic experience for the therapist" (p. 278). I experienced a sense of loss especially due to the last session I had with this client. During this session the client disclosed some experiences that were deeply personal and from that disclosure I as a social worker saw the many different reasons to have hope and reason to move forward. I had an attachment to this client because I could understand from my own life experiences some of what it could be like to live through those experiences.

Ellis and Patel (2012) also found that there could be "self-doubts regarding professional competency" after a client's suicide (p. 278). I have to admit I did have some questions about my competency. As I mentioned previously, going through

my work with this client with my clinical supervisor and discussing the case during group consultation as well as on an ad hoc basis with other therapists helped me to recognize that I followed proper protocol in working with this person. Again the biggest part was the sadness over the loss of hope paired with the beautiful things I saw as a social worker in this person in spite of the debilitating pain. I found what was helpful for me to process my loss was my faith. Part of my faith includes the existence of an after-life where one is free of pain and this person had suffered a great deal of long term pain.

Gulfi, Dransart, Heeb and Gutjahr (2010) reported that "stronger reactions were… observed among professionals who reported feeling… close to their deceased patient" (p. 207). The type of work I did at the FEC and the key role relationships played with my work did cause some intense emotions on my part. As I write about this experience now, I still experience a sense of sadness about the death of this client. To me loss is an important part of life, as that is often where beautiful things can be discovered. Again, the support provided by the different types of supervision offered by FEC was more than enough to help me to journey on from this loss.

I think Ingram's (2013) model describing a quadrant of four possibilities in the provision of supervision can offer more insight of this practicum experience. The quadrants being: focus on emotional elements; focus on balance between emotional elements and practical/process issues; focus on process and practical issues; and no emphasis on emotional or practical issues.

I would have to say my experience with supervision at the Family Enrichment Centre was an overall balance between the emotional elements and

practical/process issues. There are a few examples that could assist in illustrating this balance. The first example would be the regularly scheduled group case consultations staff meetings with one person starting the meeting with their own experience of spirituality through some type of interactive exercise.

The group case consultation was set up for the counsellors to discuss ideas for possible direction in cases that had some not typical complexities. The discussions centred specifically on process and practicalities in providing quality service to the individuals/families receiving counselling service. There may be some discussion of emotions with the meeting however the focus was definitely processes and practicalities.

The meeting where one shared their own spiritual experiences was definitely an emotional experience where we were all encouraged to share from our personal experiences. What comes to mind for this social worker during one of the meetings was my sharing the experience of visiting my father who was residing in a long-term care facility. My father had advanced Alzheimer's dementia, Parkinson's disease, was legally blind without his glasses, hard of hearing in both ears, and had experienced many traumatic events from childhood and serving in Italy during WWII. My father could not walk so was either in bed or in a manual wheel chair. He could not wear his eye glasses or hearing aids because he would immediately throw them away from himself when a caregiver tried to put them on him.

I was visiting my father and brought a plastic cup of butterscotch ice cream with a tiny wooden spoon. My father was unable to speak or recognize anyone that came to visit. Moment by moment though I was able to connect with my father as I

watched him enjoy the ice cream I was feeding to him. My cousin was at the Family Enrichment Centre meeting where I was sharing this and then shared her own account of her father's (my father's younger brother) experience of this same situation.

My uncle had also come to visit my father that afternoon and when he had observed me feeding my father some ice cream, he did not enter the room but just observed the interaction. I did not know my uncle was there at the time. My uncle was very moved by this interaction and spoke with my cousin (his daughter) about it. He asked if she would feed him ice cream when he is older and did not have all of his faculties. This was an example of the spiritual exercises validating the experiences that nurture connections between people and that in turn make the world a better place.

The experience illustrated to me the beauty found in the midst of suffering and loss. This emotional experience influenced my approach to clients by highlighting the importance of emotional connections, especially in the midst of suffering and loss. When paired with the practical/process tools that were also very much emphasized at the Family Enrichment Centre, embracing the emotional experiences proved to be a very powerful tool when working to develop rapport with the individuals and couples I worked with during my practicum.

Golia and McGovern (2015) discuss peer supervision using three categories: facilitated peer supervision, planned peer supervision and ad hoc peer supervision. The experience with peer supervision was more of a combination of facilitated peer

supervision and ad hoc peer supervision. The two types of peer supervision both had their advantages during the practicum.

The facilitated peer supervision as mentioned previously was held once every two weeks and was facilitated by the agency's Executive Director who was also a practicing clinical psychologist. The supervision was very rich with knowledge and practical experience that was helpful especially for difficult cases. Although the group was facilitated by the Executive Director, everyone present was given the opportunity to contribute to the discussions. It was usually left up to the counsellor presenting to decide what part of the discussion would be useful in case a plan would be formulated on a group consultation form (see Appendix D for group consultation form).

The peer supervision/group consultation was one that was not egalitarian in structure as the Executive Director always had the final say on how any particular case was to be approached. In practice though, I did not experience any peer supervision group meetings where there was no consensus among the participants in the specific direction that was to be taken in the cases presented. I found the ability to come to consensus brought a level of respect to the experience and knowledge every participant brought into the group discussions. This respect was important for enriching the practicum experience because it created the sense of a safe work environment. It was safe in the sense of being supported and respected by co-workers, which in turn gave me a sense of self-confidence as a student to practice well.

The ad hoc supervision was encouraged within the agency and would occur spontaneously. The ability to approach other clinicians was very helpful to not only talk about challenges but to also share successes. These discussions would then sometimes get into subtle points about counsellor-client dynamics and one's own experience with transference and countertransference issues and how these were used to advantage with clients.

In the next chapter I will discuss the conclusions I came to about the experience of my practicum at the Family Enrichment Centre, including my thoughts, feelings and gratitude for the opportunity to work at such an agency. There will also be some discussion about the possible implications for social work practice.

Chapter 4 - Conclusion and Implications for Practice

The Family Enrichment Centre was an agency closely affiliated with the Roman Catholic Sisters of St. Joseph. Their mission statement communicated that they were committed to helping people in the community that were in need of mental health services and had fallen through the cracks. To enable the agency to follow through with this mission, there was a need to find sources of funding to enable them to serve the most vulnerable in the Greater Sudbury community.

This need for support meant the Executive Director and Board of Directors needed to be quite inventive in order to maintain an adequate source of funds without any formal government assistance via grants or loans. The agency received donations from individuals, a community bingo, an annual theatre fundraiser, business donations, EAP, and clients who did not require fees for service to be subsidized. This funding and lack thereof had an impact on service provision, directly and indirectly, during this social worker's practicum at the Centre.

I was able to apply the strengths perspective in practice, and experience creative reflexive supervision that allowed for an excellent learning experience. To this social worker, it was evident that, even though there are many challenges to social service agencies in providing reflective supervision, it can be done very well. in spite of these sometimes seemingly opposing forces, the agency was able to provide an excellent service to the community. The opposing forces included a low level of financial resources and the extra effort needed to attract and keep qualified staff over the long term. FEC would often receive referrals from large and small

community service organizations that were most often fully or largely government funded and was able to accomplish what the government funded agencies could not with the clients that did not fit well within their established programs or who were on waiting lists for the same.

In an environment characterized by a spirit of hospitality, trust and acceptance, the Family Enrichment Centre was committed to providing services that were grounded in compassion, respect, justice and care for all; were responsive to the vulnerable and those in need in our community within the limits of practical charity; and promoted healthy relationships. This commitment seemed to be consistently followed during this student's practicum at the Family Enrichment Centre, a very impressive feat in the face of the resource challenges it faced.

The above description of hospitality, trust and acceptance was not only extended to the community served, it was also the working atmosphere for the staff. Individual clinical supervision, although not always available on a regular basis when offered within this environment, worked to encourage and support this social worker in practicing reflexivity within his practicum.

To make up for the lack of individual supervision, the Executive Director set up some structures within the agency that more than made up for the individual supervision and worked to create an atmosphere of professionalism, support and trust. The regular group consultation/peer supervision and regular expressions of individual spirituality were tools that provided a level of high quality supervision and reflexivity. The regular group consultation helped to build and maintain an environment where we all could support one another with our collective years of

clinical experience and expertise. The regular expressions of individual spirituality also brought a sense of cohesion, almost a sense of family among the staff. The Executive Director was creative in managing elements to this practicum experience that added to the reflective learning environment for this student. An obvious example of this creativity was suggesting that this student take part in the inhouse anger management group. A subtle example of the reflexive supervision available within FEC was the environment that was encouraged and maintained through the regular group consultation/supervision as well as regularly scheduled spiritual expressions. This environment invited individual consultations between counsellors on an ad hoc basis that allowed this student to gain access to a wealth of knowledge and experience on an individual basis in a manner that was more conducive to learning because it was more egalitarian in nature.

This particular non-profit non-government funded agency did not have a lot of resources when compared to even partially government funded non-profit agencies, yet FEC found ways to do much with the little they did have. The funding resources were stretched, however, in some ways the difficulties allowed FEC more freedom to think outside the proverbial box which helped create an environment that encouraged a high degree of professionalism and quality service. These facets were what kept counsellors on staff for any length of time (and there were some long term counsellors working there) as FEC was only able to pay their employees at the lower end of the pay scale for their professional services.

The FEC practicum experience provided a rich learning experience that fit well with my plans to continue to provide counselling and psychotherapy services

as a social worker. If I could have financially afforded to stay at FEC, I definitely would have as I have never in my decades of work in human service agencies worked in such a rich environment for professional growth, with structures set up to help ensure high quality customer service.

The Executive Director, who was also my Clinical Supervisor, was a huge reason FEC was able to be as effective as it was. I think a large part of the reason for this success (besides her intelligence, skill and experience) was that her work was a religious vocation or calling, which adds a very personal dynamic of connection between the divine and the presence of the divine in the people she served. She often could be seen working in her office well past regular working hours during the week and sometimes into the weekends. This woman was central to making FEC work as well as it did.

Dr. McKechnie oversaw the administration of the agency, provided the only psychological front line services within the agency, was involved in fundraising for the agency, and took a very active role in ensuring the agency environment was one of support and care for FEC's employees and clients. She was very good at providing and keeping an eye open for high quality and low cost professional development opportunities for the counsellors. The Motivational Interviewing workshop was one such example of low cost high value professional development that this student was able to take part in.

The weakness of FEC was the lack of resources to be able to maintain professional staff over the long-term. There was a long-term counsellor who had worked there for many years and was very dedicated to FEC. The worker had to

leave to take another higher paying position with a government funded organization. The counsellor had children approaching the age for postsecondary education and wanted to be able to help them out financially.

My professional experiences since this 2011 practicum provide some anecdotal evidence of the benefits of the FEC practicum experience. It provided a solid base upon which to develop professionally as a social worker. The improved ability to develop rapport with clients paired with the use of evidence-based practice significantly improved my ability to work with clients in the therapeutic social work setting. Other anecdotal evidence that suggests an enhanced professional ability is feedback from my clients to my current employer as well as talk about the quality of my work within the community I provide service.

I have found that experiential learning actually enhances my ability to learn within an academic environment. Experiential learning is my preferred learning style largely because it was necessary to learn to look after the emotionally wounded parts of myself during times when I was vulnerable. I did not have much academic background during these times, yet I got through them so I could experience academia. Academia enriched something I already possessed, expertise in survival and finding ways to go on with life. Social work requires that I also recognize my own strengths and am reflexive. FEC allowed this wounded healer an opportunity to greatly expand his ability to look after himself well. My practicum definitely had a huge effect on my ability to provide very competent counselling and psychotherapeutic social work services.

My experience working as a social worker student, within a setting that provided opportunities for reflexivity and a focus on helping people to discover strengths they never knew they had, provided an enriched ability to grow personally and professionally. I do not think I would have been able to experience the professional growth I have experienced without the personal growth. The two for me seem to be intricately intertwined. FEC had the balance of both of these elements in a manner that worked well for this social work student.

Thank you Dr. Josie McKechnie and staff at the Family Enrichment Centre of Sudbury, Ontario. It is sad that the Centre had to close its doors in 2015. You can be sure that the former employees of the Centre will be bringing their rich personal and professional experiences with them and benefiting others in the process. My experience at FEC has definitely allowed me to do so.

References

Beddoe, L. (2010). Surveillance or reflection: Professional supervision in the risk society. *British Journal of Social Work*, *40*, 1279-1296.

Berzoff, J., & Drisko, J. (2015). What clinical social workers need to know: bio-psycho-social knowledge and skills for the twenty first century. *Clinical Social Work Journal,* 43, 263-273.

Butler, A., Ford, D. and Tregaskis, C. (2007). Who do we think we are? Self and reflexivity in social work practice. *Qualitative Social Work,* 6:3, 281-299.

Carpenter, J., Webb, C., & Bostock, L. (2013). The surprisingly weak evidence base for supervision: findings from a systematic review of research in child welfare practice. *Children and Youth Services Review,* 35, 1843-1853.

Carroll, M. (2009). Supervision: critical reflection for transformational learning, part 1. *The Clinical Supervisor,* 28, 210-220.

Cruz, H., Gillingham, P. and Melendez, S. (2007). Reflexivity, its meanings and relevance for social work: a critical review of the literature. *British journal of Social Work,* 37, 73-90.

Cruz, H., Gillingham, P. and Melendez, S. (2007). Reflexivity: A concept and its meanings for practitioners working with children and families. *Critical Social Work,* 8(1), n.p.

Dietz, C. (2000). Responding to oppression and abuse: a feminist challenge to clinical social work. *Affilia*, 15:3, 369-389.

Douglas, E., McCarthy, S., & Serino, P. (2014). Does a social work degree predict practice orientation? Measuring strengths-based practice among child welfare workers with the strengths-based practices inventory-provider version. *Journal of Social Work Education*, 50, 219-233.

Ellis, T. and Patel, A. (2012). Client suicide: what now? *Cognitive and Behavioral Practice,* 19, 277-287.

Forde, C. and Duvvury, N. (2016, June 16). Sexual violence, masculinity, and the journey of recovery. *Psychology of Men & Masculinity,* doi:10.1037/men0000054.

Geller, J. and Dunn, E. (2011). Integrating motivational interviewing and cognitive behavioral therapy in the treatment of eating disorders: tailoring interventions to patient readiness for change. *Cognitive and Behavioral Practice*, 18, 5-15.

Geyer, S. (2010). Strengths-based groupwork with alcohol dependent older person. *Groupwork,* 20(1), 63-86.

Golia, G., & McGovern, A. (2015). If you save me, I'll save you: the power of peer supervision in clinical training and professional development. *British Journal of Social Work*, 45, 634-650.

Gulfi, A., Dransart, D., Heeb, J. and Gutjahr, E. (2010). The impact of patient suicide on the professional reactions and practices of mental health caregivers and social workers. *Crisis,* 31:4, 202-210.

Guo, W. & Tsui, M. (2010). From resilience to resistance: a reconstruction of the strengths perspective in social work practice. *International Social Work,* 53:2, 233-245.

Ingram, R. (2013). Emotions, social work practice and supervision: an uneasy alliance? *Journal of Social Work Practice*, 27:1, 5-19.

Lietz, C. (2007). Strengths-based group practice three case studies. *Social Work with Groups*, 30: 2, 73-87.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* 72 Spring Street, New York, NY: The Guilford Press.

Lynch, R., Trost, W., Salsman, N. and Linehan, M. (2007). Dialectical behaviour therapy for borderline personality disorder. *Annual Review of Clinical Psychology,* 3, 181-205.

MacIntosh, H. and Johnson, S. (2008). Emotionally focused therapy for couples and childhood sexual abuse survivors. *Journal of Marital and Family Therapy,* 34:3, 298-315.

Manthey, T., Knowles, B., Asher, D., & Wahab, S. (2011). Strengths-based practice and motivational interviewing. *Advances in Social Work,* 12:2, 126-151.

Paul, R. and Elder, L. (2007). Critical Thinking: the art of Socratic questioning. *Journal of Developmental Education,* Vol. 31 No. 1 (Fall 2007) p. 36-37

Saleebey, D. (2001). The diagnostic strengths manual? *Social Work*, 46:2, 183-187

Shaeffer, Z. (2014). Transference, countertransference, and mutuality in relational social work with college students. *Clinical Social Work Journal,* 42, 13-21.

Schamess, G. (2006). Transference enactments in clinical supervision. *Clinical Social Work Journal,* 34:4, 407-425.

Sherwood, E. (2009). Clinical assessment of Canadian military marriages. *Clinical Social Work Journal*, 37, 332-339.

Thompson, R., Arnkoff, D., and Glass, C. (2011). Conceptualizing mindfulness and acceptance as components of psychological resilience to trauma. *Trauma, Violence, & Abuse,* 12:4, 220-235.

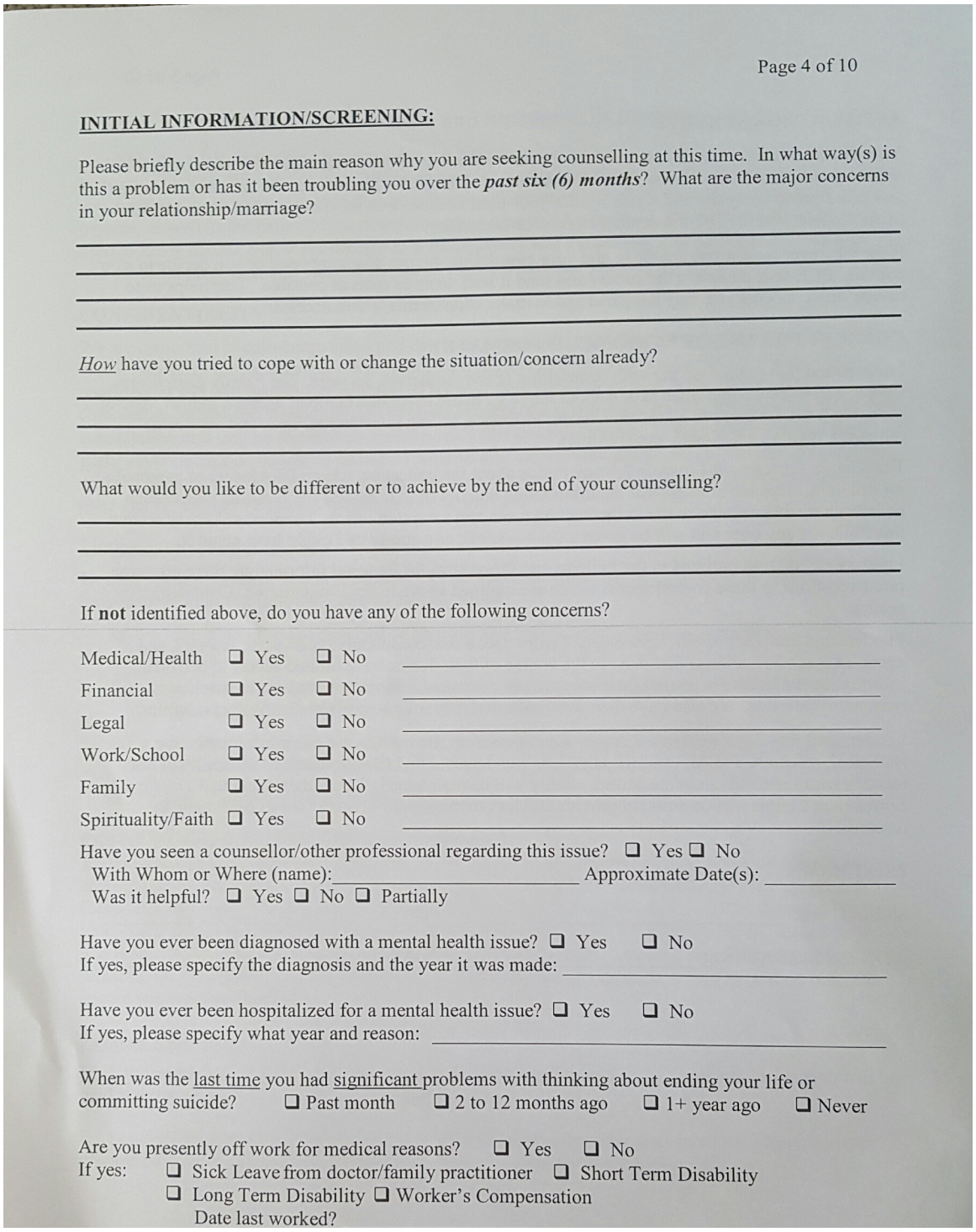
Tsui, M. (1997). The roots of social work supervision: an historical perspective. *The Clinical Supervisor,* 15:2, 191-198.

White, V. (2015). Reclaiming reflective supervision. *Practice: Social Work in Action,* 27:4, 251-264.

Wood, A., Linley, P., Maltby, J., Kashdan, T. and Hurling R. (2011). Using personal and psychological strengths leads to increases in well-being over time: A longitudinal study and the development of the strengths use questionnaire. *Personality and Individual Differences,* 50, 15-19.

Yip, K. (2003). A strengths perspective in working with an adolescent with dual diagnosis. *Clinical Social Work Journal*, 31:2, 189-203.

Appendix A – Part of FEC initial psychosocial assessment (page 4 of 10)



Page 4 of 10

INITIAL INFORMATION/SCREENING:

Please briefly describe the main reason why you are seeking counselling at this time. In what way(s) is this a problem or has it been troubling you over the ***past six (6) months***? What are the major concerns in your relationship/marriage?

_____

_____

_____

_____

How have you tried to cope with or change the situation/concern already?

_____

_____

_____

What would you like to be different or to achieve by the end of your counselling?

_____

_____

_____

If **not** identified above, do you have any of the following concerns?

Medical/Health ❑ Yes ❑ No _____

Financial ❑ Yes ❑ No _____

Legal ❑ Yes ❑ No _____

Work/School ❑ Yes ❑ No _____

Family ❑ Yes ❑ No _____

Spirituality/Faith ❑ Yes ❑ No _____

Have you seen a counsellor/other professional regarding this issue? ❑ Yes ❑ No
With Whom or Where (name):_____ Approximate Date(s): _____
Was it helpful? ❑ Yes ❑ No ❑ Partially

Have you ever been diagnosed with a mental health issue? ❑ Yes ❑ No
If yes, please specify the diagnosis and the year it was made: _____

Have you ever been hospitalized for a mental health issue? ❑ Yes ❑ No
If yes, please specify what year and reason: _____

When was the last time you had significant problems with thinking about ending your life or committing suicide? ❑ Past month ❑ 2 to 12 months ago ❑ 1+ year ago ❑ Never

Are you presently off work for medical reasons? ❑ Yes ❑ No
If yes: ❑ Sick Leave from doctor/family practitioner ❑ Short Term Disability
❑ Long Term Disability ❑ Worker's Compensation
Date last worked?

Appendix B – Part of FEC initial psychosocial assessment (page 5 or 10)

On the following pages you will find some additional screening questions we would like you to complete. These help us to see if any other condition(s) are present that might affect your problem or your ability to participate in your therapy at the present time.

ALCOHOL AND DRUG USE HISTORY:

Many people use substances such as alcohol or drugs. We would like to know about your typical pattern of use; that is how OFTEN and how MUCH you use. ***For example:*** If in the last year (12 months) you typically drink two glasses of wine on the weekend you would put "2 drinks" in the fourth column (1-2 times per week). If you smoke a ½ joint of marijuana every day you would indicate this in the last column. If you never used something you would place an "X" under never.

~ EXAMPLE ~	Never	Less than once per month	1 to 3 times per month	1 to 2 times per week	3 times per week or more
Alcohol (Standard drinks)				*e.g., 2 DRINKS*	
Marijuana					*e.g. ½ JOINT*

During the **last 12 months** how **often** and how **much** did you typically use:

	Never	Less than once per month	1 to 3 times per month	1 to 2 times per week	3 times per week or more
Alcohol					
Cannabis (Marijuana)					
Cocaine/Crack					
Other Illicit Drugs or Non-prescribed medications: (e.g. oxycontin) Specify (name): _____ _____					
Tobacco (# cigarettes)					
Caffeine (how many cups)					

Have you tried to cut-down on your alcohol or drug use? ❑ Yes ❑ No

Have you ever been annoyed when people commented on your drinking or drug use? ❑ Yes ❑ No

Have you ever felt guilty or badly about your drinking or drug use? ❑ Yes ❑ No

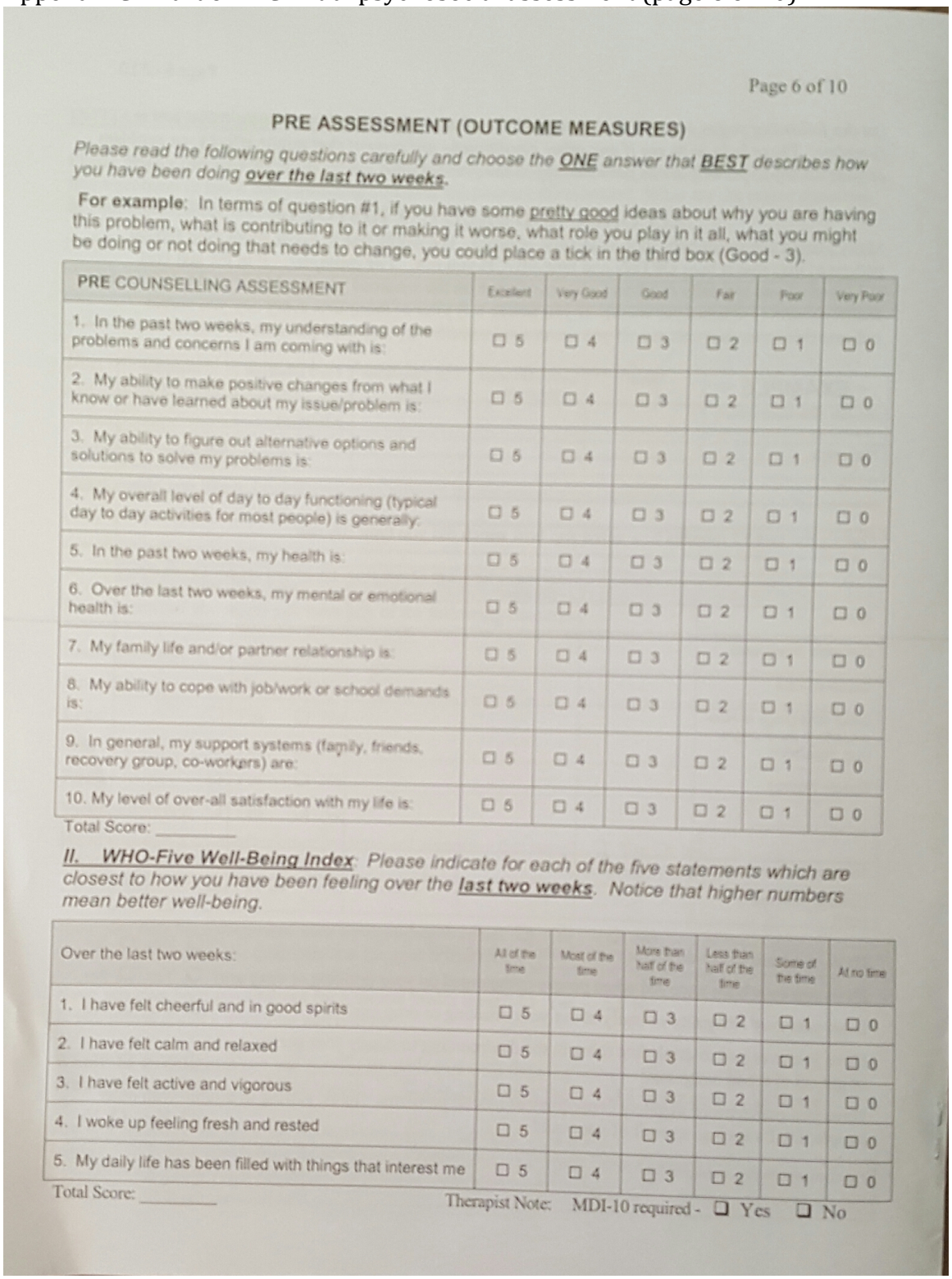
Have you ever had to drink first thing in the day/morning to steady your nerves or get rid of a bad hangover? ❑ Yes ❑ No

Have you experienced negative consequences (social problems, fights, getting in trouble with other people, DUI's etc.) as a result of your use? ❑ Yes ❑ No

For Counsellor Review and Notes Only:

Further: AUDIT ❑ DAST-20 ❑ ADAT ❑

Appendix C – Part of FEC initial psychosocial assessment (page 6 of 10)



Page 6 of 10

PRE ASSESSMENT (OUTCOME MEASURES)

*Please read the following questions carefully and choose the **ONE** answer that **BEST** describes how you have been doing **over the last two weeks**.*

For example: In terms of question #1, if you have some pretty good ideas about why you are having this problem, what is contributing to it or making it worse, what role you play in it all, what you might be doing or not doing that needs to change, you could place a tick in the third box (Good - 3).

PRE COUNSELLING ASSESSMENT	Excellent	Very Good	Good	Fair	Poor	Very Poor
1. In the past two weeks, my understanding of the problems and concerns I am coming with is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. My ability to make positive changes from what I know or have learned about my issue/problem is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3. My ability to figure out alternative options and solutions to solve my problems is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. My overall level of day to day functioning (typical day to day activities for most people) is generally:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5. In the past two weeks, my health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6. Over the last two weeks, my mental or emotional health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7. My family life and/or partner relationship is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
8. My ability to cope with job/work or school demands is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
9. In general, my support systems (family, friends, recovery group, co-workers) are:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10. My level of over-all satisfaction with my life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Total Score: _____

***II. WHO-Five Well-Being Index**: Please indicate for each of the five statements which are closest to how you have been feeling over the **last two weeks**. Notice that higher numbers mean better well-being.*

Over the last two weeks:	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1. I have felt cheerful and in good spirits	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. I have felt calm and relaxed	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3. I have felt active and vigorous	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. I woke up feeling fresh and rested	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5. My daily life has been filled with things that interest me	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Total Score: _____ Therapist Note: MDI-10 required - ❑ Yes ❑ No

Appendix D – FEC record of Group Consultation and/or Supervision

FAMILY ENRICHMENT CENTRE

RECORD OF SUPERVISION and/or GROUP CASE CONSULTATION 2014

CLIENT INITIALS: _____ FEC FILE #: _____SEX: ____ AGE:____ D.O.B._____

DATE REVIEWED: _____

Josie McKechnie, Ph.D.	☐	Adriana Gorski, MA	☐	Mark Hurley, BSW	☐
Carol Boyd, CAPPE	☐	Heather Smith, MSW	☐	Vivian Munroe, BSW	☐
Carmel Girouard, MSW	☐	Harriet Kideckel, MSW	☐	Larry Dahmer, RSW,MA	☐
Debbie Smith, CAPPE	☐	Marcel Desjardins, CACC	☐	Colleen Thompson, MA	☐

BRIEF HISTORY: Date First Session: _____ Number of Sessions to Date: _____

_____

_____

_____

_____

ISSUES/CONCERNS ADDRESSED: (Note - Clinical supervision is to assist the supervisee to: safeguard the welfare of the client, discuss the direction of therapy and the therapeutic relationship, promote the professional growth of the supervisee/staff, and enhance the supervisee's safe and effective use of self in the therapeutic relationship.)

1. _____

2. _____

RECOMMENDATIONS:

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

THERAPIST SIGNATURE & TITLE: _____

CLINICAL SUPERVISOR SIGNATURE (IF APPLICABLE):_____

S:\Forms for Counsellor Use\Record of Supervision.doc

Appendix E – FEC copy of The Major (ICD-10) Depression Inventory (MDI-10)

The Major (ICD-10) Depression Inventory (MDI-10)

Name: _____ FEC #: _____

Date: _____

The following questions ask about how you have been feeling over the last two weeks. Place a tick in the box which is closest to how you have been feeling.

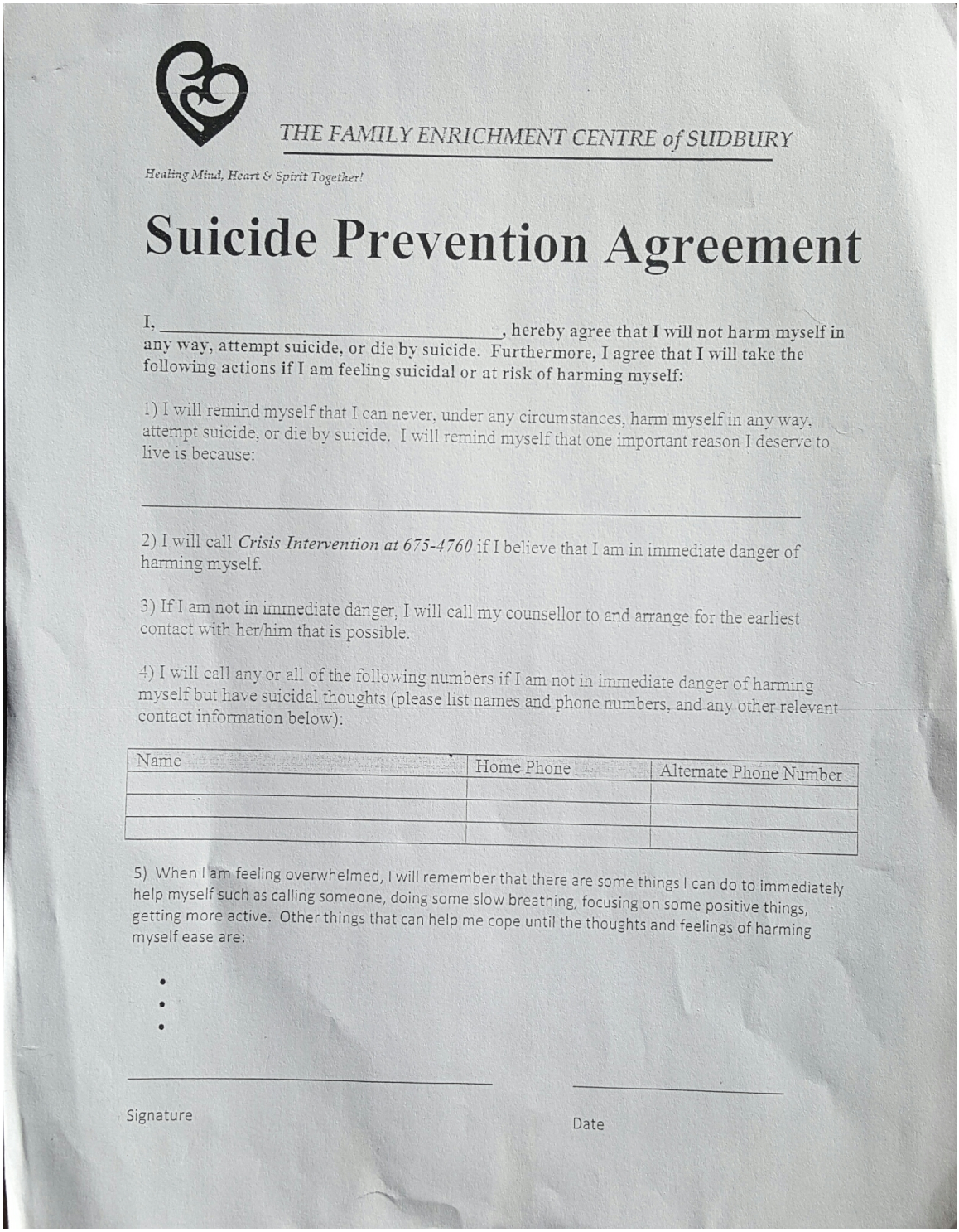
For example: If you have felt in low spirits or sad slightly more than half of the time during the last two weeks put a tick in the third box from the left in the first row.

	How much of the time . . .	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	Have you felt in low spirits or sad?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	Have you lost interest in your daily activities?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	Have you felt lacking in energy and strength?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	Have you felt less self-confident?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	Have you had a bad conscience or feelings of guilt?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6	Have you felt that life wasn't worth living?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7	Have you had difficulty in concentrating, e.g. when reading the newspaper or watching television?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
8a	Have you felt very restless?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
8b	Have you felt subdued? (quiet, low keyed, toned down)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
9	Have you had trouble sleeping at night?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10a	Have you suffered from reduced appetite?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10b	Have you suffered from increased appetite?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Total Score: _____

Source: World Health Organization (WHO), Psychiatric Research Unit, WHO Collaborating Centre in Mental Health, North Zealand, Hillerod

Appendix F – FEC Suicide Prevention Agreement



THE FAMILY ENRICHMENT CENTRE of SUDBURY

Healing Mind, Heart & Spirit Together!

Suicide Prevention Agreement

I, _____, hereby agree that I will not harm myself in any way, attempt suicide, or die by suicide. Furthermore, I agree that I will take the following actions if I am feeling suicidal or at risk of harming myself:

1) I will remind myself that I can never, under any circumstances, harm myself in any way, attempt suicide, or die by suicide. I will remind myself that one important reason I deserve to live is because:

_____

2) I will call *Crisis Intervention at 675-4760* if I believe that I am in immediate danger of harming myself.

3) If I am not in immediate danger, I will call my counsellor to and arrange for the earliest contact with her/him that is possible.

4) I will call any or all of the following numbers if I am not in immediate danger of harming myself but have suicidal thoughts (please list names and phone numbers, and any other relevant contact information below):

Name	Home Phone	Alternate Phone Number

5) When I am feeling overwhelmed, I will remember that there are some things I can do to immediately help myself such as calling someone, doing some slow breathing, focusing on some positive things, getting more active. Other things that can help me cope until the thoughts and feelings of harming myself ease are:

-
-
-

_____ _____

Signature Date